LifeWays
Community Mental Health

Notice of Final Operating Procedure

Attached is the final operating procedure regarding Claims Payment. (**The revised, and clean final copy of the Procedure are both attached to this document**.)

Thank you for your participation in this review process.

Proposed Policy/Procedure(s): 3-04.08 Claims Payment

Purpose: **The purpose of this operating procedure is to clarify that providers contracting with LifeWays must comply with data/claims submission guidelines as specified within the Operating Procedure.**

Feedback Due: **SEPTEMBER 1, 2015**

eMail Comments to: **shannan.clevenger@lifewayscmh.org**

Mail Comments to: Shannan Clevenger, Chief Operating Officer
1200 N. West Ave
Jackson, MI 49202

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0~~7~~8 ~~Clean~~ Claims Payment			
	6/23/14	**REVIEWED/REVISED:**	~~9/26/14~~09/01/2015

3.04.0~~7~~8 Claims Payment

Purpose: The purpose of this operating procedure is to clarify that providers contracting with LifeWays must comply with data/claims submission guidelines specified below.

Procedure: Claims should be submitted through a **837 File Transfer. If an alternate claims submission process has been agreed upon it must be specifically referenced in the Provider's contract what mode of claim submission is acceptable.**

1. Community Inpatient Providers	Form HCFA 1500 **or UB 04**
2. Providers Connected Electronically	via LEO **or 837 File**
3. All Others	Form HCFA 1500 **or UB 04**

Electronically submitted claims via LEO are processed by noon on the 2nd LifeWays working day, after the 15th of the month and by noon on the 3rd LifeWays working day, after the last day of the month. Claims are posted numerically by batch number and can only be posted until 5:00 p.m. on the day before claims are processed for payment to providers. Claims processing dates will be posted and updated on the LifeWays web site.

Claims received after **forty-five (45)** days of the delivery of the service **will not be paid.**

A clean claim meets all of the following criteria:

1. The service(s) that constitute the claim has/have been authorized.
2. The service(s) has/have been provided and properly documented (including accurate start and stop times) according to source document requirements.
3. The service(s) must be reimbursable as defined in the master contract between LifeWays and the provider.
4. The service(s) is/are submitted to LifeWays without errors, all required data elements associated with the specific claim are present and in standardized format.
5. The claim(s) has/have been received by LifeWays within **forty-five (45)** days of service delivery.
6. Fee Determination is complete and verified, and all supporting documentation is in place.
7. All data elements required contractually are complete for the consumers.
8. Medical record documentation supports medical necessity and service description criteria.
9. Provider has verified the consumer's Medicaid eligibility at the time the service prior to billing LifeWays for reimbursement.

~~9.~~ No overlapping SAL except for allowable codes per MDCH PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes ~~(Treatment Planning, Behavior Treatment Plan Review and any perdiem service.) and the Medicaid Autism Benefit.~~

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Community Inpatient Providers (Hospitals)

Inpatient providers submit claims on Form HCFA 1500/UB 04, for consumer days of care charges, and for all applicable psychiatric services, and a summary sheet indicating by consumer, the total days, per diem charges and physician charges.

The provider shall process billings from and payments to physicians and other professionals for services delivered to consumers admitted pursuant to the provider contract, that are not otherwise reimbursed by another third party.

All claims must list the authorization number assigned to the episode by LifeWays.

The hospital must diligently pursue all available third-party reimbursement for inpatient and psychiatric services provided, prior to submitting claims to LifeWays. For those consumers for whom the provider renders psychiatric services admitted pursuant to the provider contract and who are ineligible for third-party reimbursement or insurance benefits due to benefit exhaustion, LifeWays may be billed according to the following provisions:

1. For each public or Medicaid consumer day of care at the agreed upon rate as specified in the provider contract.

2. For professional psychiatric procedures delivered which are listed in the provider contract at the approved rate also identified in the provider contract.

3. The provider will produce evidence that a Medicaid application was completed and submitted when a consumer has no insurance and meets financial eligibility standards.

4. The authorization number issued by LifeWays Access must be listed on each claim.

5. An explanation of benefits or any other official report received by insurances indicating the amount covered by those insurances and LifeWays' liability.

6. Clean claims will be paid within thirty days (30) of submission.

7. ~~Claims that are submitted ninety (90) days or later from date of service~~ **will not be paid. ?? thoughts??? Will a hospital be able to bill in that time frame if they bill 1stand 3rd party payers?**

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PROVIDERS CONNECTED ELECTRONICALLY

Submitting Claims

See LEO's help button for instructions, under Provider Claims User Manual.

All Others

Providers that are not on LEO must submit their claims on HCFA 1500/UB04 form. This document serves as a reimbursement invoice.

The Provider must complete these required fields on the HCFA 1500/UB04 form:

2. Client/Consumer Last and First Name
3. Client/Consumer Birth Date
5. Client/Consumer Address
21. Diagnosis
23. LifeWays Authorization Number
24 A. Dates of Service From and To
24 B. Place of Service
24 D. CPT/Service Code
24 F. Total Units/Days
25. Provider Tax ID Number and check box that applies
26. LEO ID Number for Client/Consumer
28. Total Charge Amount for Sheet
32. Facility location where service was performed
33. Billing Provider
33 A. NPI Number (National Provider Identifier)

AUTHORIZATION FOR SECONDARY COVERAGE

The LifeWays Network Provider must follow the same ~~LifeWays review~~ procedures as those described in the primary payer review procedures. The LifeWays Network Providers are required to assist LifeWays in the management of secondary payer cases. LifeWays Network Providers must notify LifeWays of all pertinent employer and insurance information for the LifeWays consumer being treated. By working collectively when these situations surface, a duplication of the authorization and review process can be avoided. Additionally, the provider shall accept payment received under the LifeWays contract as payment in full for the cost of service and shall not bill consumers, consumer families or other third parties directly for services

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paid by LifeWays unless otherwise allowed in the LifeWays provider contract. LifeWays should only be billed if the consumer has ~~Standard~~ Medicaid as their secondary payer.

LifeWays Network Providers are responsible for obtaining authorization from primary coverage payers prior to calling Utilization Management for authorization. Failure to seek appropriate prior authorization from the primary insurance or LifeWays will result in a denied claim. If payment is received from a primary insurance, LifeWays is only responsible for the contracted Medicaid co-insurance~~pay~~ amount. ~~.~~ LifeWays should only be billed if the consumer has ~~Standard~~ Medicaid as their secondary payer. An Explanation of Benefits must be received in LifeWays Finance Department prior to payment being issued to verify the billed amount is correct. The Explanation of benefits must be submitted within 14 days of receipt of payment. Patient pay responsibility must be adjudicated prior to the billing to LifeWays for any co-insurance.

PAYMENTS:

Fee-for-Service contract payments are made on the following schedule:

LifeWays reviews claims until 12:00 p.m. on the 2nd working day after the fifteenth of the month; on the 5th working day after the 15th of the month and process for payment, all non-paid clean claims for services provided within the last **forty-five (45)** days.

LifeWays reviews claims until 12:00 p.m. on the 3rd working day after the end of the month. On the 6th working day after the end of the month and process for payment, all non-paid clean claims for services provided within the last **forty-five (45)** days.

Payments are based on the agreed upon rates as specified in the Provider Manual and the clean claims processed for the pay period. Each payment is accompanied by a Payment Request Report and providers can print their remittance advice report that lists, by consumer, the type, date of service, the amount paid, denied claims and the reason for denial. The Reconsideration Payment Request report also indicates any adjustments made to the claims after the reports were printed. Payments will be available for pick up (contact Accounts Payable in Finance prior to the mail date to arrange for pick up) or mailed by 5:00 pm on the following dates. Contract payment dates will be posted on LifeWays web site.

Claims Investigation

LifeWays Network Contracts Team conducts scheduled and unscheduled billing reviews to verify compliance with claims submission standards. Providers are notified in writing of any identified deficiencies. A formal Plan of Improvement may be requested. It is critical to LifeWays that appropriate resolution occurs in a timely manner. Failure to comply with claims submission guidelines may result in a request for reimbursement, which will be deducted from a future payment. See the Appeals and Dispute Section of your Provider Manual for instructions on how to appeal a claim.

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Repayment of Claims

It is the provider's responsibility to notify LifeWays in writing of any claims billed in error that will require repayment. LifeWays will make the adjustments in the system and will appear on the next Remittance Advice. If following a billing review a trend of abuse, chronic mistakes or potential fraud is identified or suspected, such as no documentation of service, LifeWays Corporate Compliance Committee shall be notified to assess further action. This may include a complete billing review of the Provider to better assess the extent of repayment, issuance of a notice of contract non-compliance and a request for corrective action and/or notification to the State of Michigan to further investigate for possible charges under the False Claims Act.

System Disaster Recovery

In the event LifeWays Claims Processing System should fail and claims cannot be processed electronically for more than one (1) payment cycle the following process should take place: The provider should log all encounters on a spreadsheet or billing form HCFA 1500/UB 04 with minimal information of:

1. Consumer ID
2. Consumers initials
3. Date of service
4. CPT/Service code
5. Units of service
6. Charge amount
7. Authorization number related to the service
8. Total amount due

This information will be submitted to the Finance Department via CD or paper copy for processing. When the electronic system is restored it will be the responsibility of each provider to enter the claims so they can be processed electronically. The same **forty-five 45-day** rule for processing dates of service will apply and the cycle will remain 1st through the 15th and 15th through the last date of the month.

REFERENCES
1. Remittance/Payment Schedule – 20154
2. HCFA 1500 Form and Instructions
~~3. LifeWays Code Sheet for Claims Submissions~~
~~4.~~3. "Place of Service" Codes Approved for Claims to LifeWays
~~5.~~4. PIHP/CMHSP Encounter Reporting: HCPCS and Revenue Codes
~~6.~~5. PIHP/CMHSP Encounter Reporting: Costing per Code

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~~7.~~6. PIHP/CMHSP Provider Qualifications per Medicaid Service & HCPCS/CPT Codes 7. ~~Allowable Overlapping service codes (see attached)~~6.02.01Grievance and Appeals Procedure 8. Michigan Medicaid Provider Manual

HISTORY	
6/23/14	Rev. 9/26/14

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3-04.08 CLAIMS PAYMENT

Purpose: The purpose of this operating procedure is to clarify that providers contracting with LifeWays must comply with data/claims submission guidelines specified below.

PROCEDURE

Claims should be submitted through a **837 File Transfer. If an alternate claims submission process has been agreed upon it must be specifically referenced in the Provider's contract what mode of claim submission is acceptable.**

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6. Fee Determination is complete and verified, and all supporting documentation is in place.
7. All data elements required contractually are complete for the consumers.

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8. Medical record documentation supports medical necessity and service description criteria.
9. Provider has verified the consumer's Medicaid eligibility at the time the service prior to billing LifeWays for reimbursement.

No overlapping SAL except for allowable codes per MDCH PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes

COMMUNITY INPATIENT PROVIDERS (HOSPITALS)

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CLAIMS INVESTIGATION

LifeWays Network Contracts Team conducts scheduled and unscheduled billing reviews to verify compliance with claims submission standards. Providers are notified in writing of any identified deficiencies. A formal Plan of Improvement may be requested. It is critical to LifeWays that appropriate resolution occurs in a timely manner. Failure to comply with claims submission

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guidelines may result in a request for reimbursement, which will be deducted from a future payment. See the Appeals and Dispute Section of your Provider Manual for instructions on how to appeal a claim.

REPAYMENT OF CLAIMS

It is the provider's responsibility to notify LifeWays in writing of any claims billed in error that will require repayment. LifeWays will make the adjustments in the system and will appear on the next Remittance Advice. If following a billing review a trend of abuse, chronic mistakes or potential fraud is identified or suspected, such as no documentation of service, LifeWays Corporate Compliance Committee shall be notified to assess further action. This may include a complete billing review of the Provider to better assess the extent of repayment, issuance of a notice of contract non-compliance and a request for corrective action and/or notification to the State of Michigan to further investigate for possible charges under the False Claims Act.

SYSTEM DISASTER RECOVERY

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REFERENCES
Michigan Medicaid Provider Manual Remittance/Payment Schedule – 2015 HCFA 1500 Form and Instructions "Place of Service" Codes Approved for Claims to LifeWays PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes PIHP/CMHSP Encounter Reporting Costing per Code PIHP/CMHSP Provider Qualifications per Medicaid Service & HCPCS/CPT Codes LifeWays Operating Procedure 6-02.01 Grievance and Appeals Procedure
HISTORY

Effective date: 06/24/2014	Rev. 9/14